

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152552		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER FRESENIUS MEDICAL CARE HENDRICKS COUNTY				STREET ADDRESS, CITY, STATE, ZIP CODE 1594 E MAIN ST STE A DANVILLE, IN 46122			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
V 000	<p>INITIAL COMMENTS</p> <p>This was a federal ESRD survey for the addition of a home training program for peritoneal and hemodialysis home training and support.</p> <p>Survey Date: February 27, 2014</p> <p>Facility #: 010185</p> <p>Medicaid Vendor #: 200181260A</p> <p>Surveyor; Bridget Boston, RN, Public Health Nurse Surveyor</p> <p>Fresenius Medical Care Hendricks County is approved to provide peritoneal dialysis and home hemodialysis training and home support.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 28, 2014</p>			V 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.